MO560-630

Neuro/Emotional/Behavioral
Status Assessment

MO560

OASIS ITEM:

(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

DEFINITION:

Identifies the patient's current level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to inpatient facility

- Observation & interview are equally important
  - Information may come from:
    - Referral sources
    - Phone call
  - Validate by what you hear & see
    - A patient who is alert & oriented:
      - Is involved in the visit.
      - Follows instructions.
      - Responds to queries.
      - Asks appropriate questions.

Changes in Cognition

- Signs of changes in cognition:
  - Has difficulty answering questions
  - Doesn't remember friends/relatives/caregivers
  - Is unable to locate meds
  - Is unsure whether she has taken meds
  - Has not bathed or eaten
  - Is unable to locate familiar objects

Verify with Caregiver

- Does the patient require reminders or cueing or repetition:
  - In stressful or unfamiliar situations?
  - In some specific situations?
  - Most of the time?

Challenges

- This item considers a patient's current level of alertness, orientation, comprehension, concentration & immediate memory.

  True or False?

- If you suspect changes in cognition, how might you proceed with the assessment?
  - a. Ask the patient directly, "Are you losing your memory?"
  - b. During observation of ADLs, use guided conversation.
  - c. Rely on the patient's report of concentration.
  - d. Rely on the caregiver's report.

MO570

OASIS ITEM:

(M0570) When Confused (Reported or Observed):

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

DEFINITION:

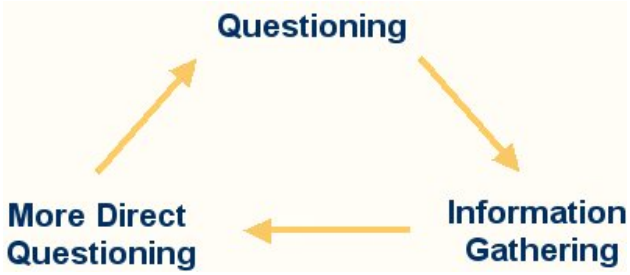
Identifies the time of day the patient is likely to be confused, if at all.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to inpatient facility

Assessment Strategies

- Use observation and interviewing
- Ask family or caregiver



Challenge

- A patient's well-developed social skills may mask mild confusion and necessitate a more integrated assessment

True or False?

MO580

OASIS ITEM:

(M0580) When Anxious (Reported or Observed):

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

DEFINITION:

Identifies the frequency with which the patient feels anxious.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to inpatient facility

Assessment Strategies

- Illness may cause anxiety about
  - Recovery
  - Financial burdens
  - Loved ones
  - Loss of independence
  - Clinician asking questions
- Observe
  - General appearance
  - Facial expressions
  - Affect
  - Motor behaviors.

Interview

- Interview begins with directed conversation
  - Explore for situations where patient is continually anxious
  - Be sure to clarify
  - Observation will determine the appropriate response to M0580

Challenge

- Anxious behaviors may be apparent or not during the visit, and if none are observed, there is no need to assess for anxiety.

True or False?

MO590

OASIS ITEM:

(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)

- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

DEFINITION:

Identifies presence of symptoms of depression.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to an inpatient facility

Importance of Depression Assessment

- Depression is
  - Common in primary care settings
  - **Underdiagnosed & undertreated**
  - Highly prevalent
  - Characterized by significant morbidity & mortality

MO610

OASIS ITEM:

(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

DEFINITION:

Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to an inpatient facility

MO620

OASIS ITEM:

(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

DEFINITION:

Identifies frequency of behavior problems which may reflect an alteration in a patient's cognitive or neuro/ emotional status. "Behavior problems" are not limited to only those identified in M0610. For example, "wandering" is included as an additional behavior problem. Any behavior of concern for the patient's safety or social environment can be regarded as a problem behavior.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to an inpatient facility

Challenge

- Assessment for M0610 can reveal other behavior problems
- Record frequency of such behaviors in M0620
- If the patient demonstrates a behavior other than those listed, you do not have to respond to M0610.

  True or False??
- In M0620, you will report the frequency of only those behaviors listed in M0610.

  True or False?

Challenge

- Which of the following would NOT be a part of your approach to assessing for the behaviors listed in M0610 & for determining the frequency of behaviors in M0620?
  - a. Assess for behaviors throughout the visit.
  - b. Review health history information for conditions predisposing to the behaviors.
  - c. Request the medical records from the physician's office before deciding to assess.
  - d. Talk with the family & caregivers about the behaviors & frequency.

MO630

OASIS ITEM:

(M0630) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 - No
☐ 1 - Yes

DEFINITION:

Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric nursing services" address mental/emotional needs; a "qualified psychiatric nurse" is so qualified through educational preparation or experience.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to an inpatient facility

Assessment Strategy

- Review referral information & other documents
- Mark 0–No–if there are no orders for mental health nursing even if you are a qualified psychiatric nurse.
- If order will be part of plan of care, mark 1–yes–even if you are not a qualified psychiatric nurse.